



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
DELAWARE BOARD OF NURSING

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

**INFORMATION SHEET REGARDING APPLICATION FOR LICENSURE
AS AN ADVANCED PRACTICE NURSE**

GENERAL INFORMATION:

1. The Delaware Nurse Practice Act requires that a current Advanced Practice Nurse Delaware temporary permit or valid Delaware license be issued to you **BEFORE** you are employed as an Advanced Practice Nurse in Delaware. A fee of \$30.00 is required for a temporary permit. Permits are processed within 7 business days from the date of your completed application, Collaborative Agreement form and a copy of your transcripts. Permits are mailed to the applicant and cannot be obtained at the Nursing Board office.

CONCURRENT REGISTERED NURSE **AND** ADVANCED PRACTICE NURSE licensure must be maintained at all times to practice as an Advanced Practice Nurse in Delaware.

2. Applicants for Advanced Practice Nurse licensure must have a Master's degree or a post-basic program certificate in a clinical nursing specialty with nursing certification from a national certification body recognized by the Board, if such certification is available.
3. The Rules and Regulations for Advanced Practice Nurses require that an Advanced Practice Nurse must practice a minimum of 1500 hours in the last five years or 600 hours in the past two years in the area of specialization in which licensure is granted. Applicable to your initial date of practice, you must fulfill this requirement to qualify for licensure, unless you are a new graduate.
4. The application becomes invalid if not completed within one (1) year.
5. The Advanced Practice Nurse license shall be assigned the same expiration schedule as the applicant's Delaware Registered Nurse license.

PROCEDURE FOR FILING APPLICATION: THIS APPLICATION DOES NOT INCLUDE THE AUTHORITY TO PRESCRIBE.

1. Complete pages 1 and 2. Be consistent in listing your name in all sections where requested.
2. The completed application must be notarized. (affidavit section, page 2)
3. Attach a copy of your original certification document or current re-certification card to the bottom of page 2. **If not yet certified, request that the certifying organization submit a letter verifying your eligibility to take the examination.**
4. Complete the collaborative agreement information and return with your application.

5. Submit the application to the Board of Nursing along with the non-refundable prorated licensure fee as listed below, made payable to the "State of Delaware".
6. Request that an official transcript from your program be submitted to the Board office.
7. Complete the top section of the Verification of National Certification page. Send this page to the appropriate certifying body that issued your national certification. There may be a fee.
8. An application for independent practice/prescriptive authority will be sent to you upon permanent Advanced Practice Nurse licensure in Delaware.

APPLICATION FOR TEMPORARY PERMIT

A fee of \$25.00 is required for a temporary permit. Permits are processed within 7 business days from the date of receipt of the Collaborative Agreement form and a copy of your transcripts. Permits are mailed to the applicant and cannot be obtained at the Nursing Board office.

If you are already licensed as a Registered Nurse in Delaware, please refer to your Delaware license number to determine your licensure group and corresponding Advanced Practice Nurse licensure fee. If you are a first time applicant as a Registered Nurse in Delaware, please refer to the Group "C" licensure fees. **APPLICANTS RESIDING IN A NURSE LICENSURE COMPACT STATE WHO ARE APPLYING ONLY FOR THE ADVANCED PRACTICE NURSE LICENSURE, SHOULD USE FEE SCHEDULE FOR GROUP "C".**

GROUP A - License Numbers **001 to 17,000**

Licensure through 2/28/07

July, 2006	\$31.00
August, 2006	\$27.00
September, 2006	\$23.00
October, 2006	\$19.00
November, 2006	\$16.00

Licensure through 2/28/09

December, 2006	\$103.00
January, 2007	\$99.00
February, 2007	\$95.00
March, 2007	\$91.00
April, 2007	\$88.00
May, 2007	\$84.00
June, 2007	\$80.00

GROUP B - License Numbers **17,001-24,000**

Licensure through 5/31/07

July, 2006	\$42.00
August, 2006	\$38.00
September, 2006	\$35.00
October, 2006	\$31.00
November, 2006	\$27.00

Licensure through 5/31/09

December, 2006	\$23.00
January, 2007	\$19.00
February, 2007	\$16.00
March, 2007	\$103.00
April, 2007	\$99.00
May, 2007	\$95.00
June, 2007	\$91.00

GROUP C - License Number **24,001 and up**

Licensure through 9/30/07

July, 2006	\$57.00
August, 2006	\$54.00
September, 2006	\$50.00
October, 2006	\$46.00
November, 2006	\$42.00

Licensure through 9/30/09

December, 2006	\$38.00
January, 2007	\$35.00
February, 2007	\$31.00
March, 2007	\$27.00
April, 2007	\$23.00
May, 2007	\$19.00
June, 2007	\$16.00

DELAWARE BOARD OF NURSING
861 SILVER LAKE BLVD.
SUITE 203
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Website: www.dpr.delaware.gov

DE RN# _____
COMPACT STATE: _____
DE APN# _____ ISSUE DATE _____

APPLICATION FOR STATE LICENSURE AS AN ADVANCED PRACTICE NURSE

I hereby make application for licensure as an Advanced Practice Nurse, (Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife (CNM), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS)), in accordance with the statutes of the State of Delaware, Title 24, Chapter 19, subsection 1902(D)1.

1. FULL

NAME: _____
Last First Middle Maiden

2. Mailing

Address: _____
Street

City State Zip Phone Number

3. Social Security Number: _____ Email Address: _____

4. Name of RN Nursing Program from which graduated: _____

Address: _____ Date of Graduation: _____

5. Name of CNM, CRNA, NP, or CNS School/Program completed: _____

Address: _____

Date of Entering Program (month/year): _____ Date of Completing Program (month/year): _____

Degree conferred: _____ Specialty Area _____

List other colleges or universities from which you hold graduate degrees, including dates and degrees

conferred: _____

6. National Certification obtained from: _____

CNM, CNS, NP, or CNS Certification was granted by: ☐ Exam ☐ Waiver

7. Other states in which you are or have been credentialed to practice as an Advanced Practice Nurse:

State _____; State _____; State _____

8. List names and addresses of employers and dates of APN employment during the past five years. If not employed as an Advanced Practice Nurse/Clinical Nurse Specialist during the past five years, submit name, address and dates of last employment as an Advanced Practice Nurse/Clinical Nurse Specialist.

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9. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction? ☐ Yes ☐ No If yes, submit a certified copy of your criminal history record.

10. Have you ever been judicially declared incompetent? ☐ Yes ☐ No

11. Have you ever had disciplinary action taken against your APN authority to practice? ☐ YES ☐ NO
If yes, in which state(s)? _____

12. Has your national certification as a CNM, CRNA, NP, or CNS been suspended, revoked or otherwise restricted?
☐ Yes ☐ No

If answer to question 9, 10, 11, or 12 is yes, submit details on a separate page.

13. The Rules and Regulations for Advanced Practice Nurses state in Section 10.2: "The APN must practice a minimum of 1500 hours in the past five years or 600 hours in the past two years in the area of specialization in which licensure has been granted." Do you fulfill this requirement? ☐ Yes ☐ No

☐ New Graduate

➤ DECLARATION OF PRIMARY RESIDENCE

I Hereby declare my State of Primary Residence to be _____. You **MUST** attach a photocopy of your driver's license or identification card issued by the State Division of Motor Vehicles.

The Board office must receive items submitted for the Board to consider at its meeting **no later than two full business days before the meeting**. In order to be considered at a Board meeting, license applications must be **complete** two full business days before the meeting. A **complete** application is one that includes all required documentation and correct payment.

Applications that are not **complete** within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your APN application is complete, please allow 6-8 weeks to receive your license. RN and APN applications can be processed simultaneously, but the APN license cannot be issued until the RN application is complete.

AFFIDAVIT

(To be completed by applicant before a Notary Public)

_____, being duly sworn, says that
he/she
Last First Middle Maiden

is the person who is referred to in the foregoing application as an Advanced Practice Nurse in the State of Delaware; that the statements therein contained are strictly true in every respect; and that he/she has read and understands this affidavit.

Signature of
applicant: _____

Subscribed and sworn to before me this _____ day of _____, 20____

My commission expires:

Signature Notary Public

(SEAL)

NOTE: Your name **MUST** appear the same in all sections of this application, including the AFFIDAVIT.

ATTACH A COPY OF YOUR CERTIFICATION CARD

DO YOU NEED A TEMPORARY PERMIT? _____ TENATIVE START DATE: _____

FOR OFFICE USE ONLY:

Category _____

Temporary Permit #:	Start	End	Supervision	Mailed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____



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COLLABORATIVE AGREEMENT INFORMATION

Advanced Practice Nurses licensed by the Delaware Board of Nursing are required to have a collaborative agreement as defined in Section 8.4 of the Board's Rules and Regulations.

ARTICLE VIII

4.4 Collaborative Agreement

Written verification of health care facility approved clinical privileges; or health care facility approved job description; or a written document that outlines the process for consultation and referral between an Advanced Practice Nurse and a licensed physician, dentist, podiatrist, or licensed Delaware health care delivery system.

Please complete the following:

TYPE OF COLLABORATIVE AGREEMENT

Please check all that apply:

- 1) ☐ Health care facility approved clinical privileges
- 2) ☐ Health care facility approved job description
- 3) ☐ Written agreement with physician, dentist, podiatrist, or licensed Delaware health care delivery system
- 4) ☐ Do not have a collaborative agreement (see below)

NAME OF PERSON/SYSTEM/FACILITY

ADDRESS

Street

City

State

Zip Code

Telephone

By my signature, I attest to the accuracy of the above information. If I do not currently have a collaborative agreement, I will submit the required information before beginning practice. I will notify the Board of changes in the person/system/facility with whom I have a collaborative agreement.

Applicant's Name

Signature

Date

VERIFICATION OF NATIONAL CERTIFICATION

TO BE COMPLETED BY APPLICANT

NAME OF APPLICANT: _____

Last

First

Middle

Maiden

MAILING ADDRESS: _____

Street

City

State

Zip Code

I authorize the release of the requested information.

Signature _____ SSN# _____

TO BE COMPLETED BY THE NATIONAL CERTIFYING ORGANIZATION

School/Program preparing Nurse Practitioner/Clinical Nurse Specialists:

NAME: _____

ADDRESS: _____

DATE OF ENTERING PROGRAM: _____ DATE OF COMPLETING PROGRAM: _____

Was School/Program approved? Yes ____ No ____ If yes, by what certifying body? _____

Was program an external degree? Yes ____ No ____

Type of Nurse Practitioner Education Program: Certificate ____ Bacc. ____ MSN ____

Area of Specialty: _____ Certification # _____

Effective Dates: By Exam _____ Waiver _____
(mmddyy) (mmddyy)

Has any disciplinary action been taken against this certificate or has the certificate ever been voluntarily surrendered? Yes ____ No ____ If YES, please submit information on a separate page.

Certificate Status: _____ Active or Current _____ Inactive or Non-Practicing
Exp. date
_____ Lapsed or Delinquent _____
Exp. Date

I certify the above information to be a true report for the above named nurse according to the records of this office.

Signature _____ Title _____ Date _____
Certifying Agency _____ (SEAL)

RETURN COMPLETED FORM DIRECTLY TO:

**DELAWARE BOARD OF NURSING
861 SILVER LAKE BOULEVARD
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